Vol. 9 December 2001

MAINE PRIME CARE UPDATE

Adult Immunization: It's That Time of Year Again

In September of this year the licensed long term care facilities in Maine received the adult immunization survey mailing. This mailing consists of a list of Maine Medicaid members residing within the facility and their pneumonia vaccine status if it is known. The Maine Medical Assistance Manual, Chapter II, Section 67.05-20, states, "Upon admission and annually every fall, each resident's immunization status shall be updated, regardless of payer. Unless medically contraindicated or refused, the standard of care is to administer an annual flu (influenza) vaccination in the fall; and a pneumonia (pneumococcal) vaccination, which may be repeated no more than every 5 years (other immunizations should be reviewed and updated as necessary). As with any treatment the resident has the right to refuse the vaccination. Each vaccination must be documented in the resident's medical record. Each refusal by the resident (or guardian) must also be document in the residents record. Annually the NF shall report to the Department, the number of residents, number and type of vaccinations administered, and the number of refusals for the reporting period." Nursing facilities are required to submit the updated roster list of members with their current immunization status to the QI Division by December 31, 2001. If facilities are unable to complete this form due to unforeseen circumstances they must notify Jean Lloyd before December of 2001. She may be reached at 287-1068.

Over the last 3 years the QI Division has noted a decline in the numbers of residents who have had pneumonia and influenza associated illnesses despite the increase in eligible beneficiaries. In the season from September of 1998 to May of 1999, Maine Medicaid had a total of 1674 claims for beneficiaries 65 or older for pneumonia and influenza associated illnesses. From September of 2000 to May of 2001, the number of claims declined to 1468. During this period the population of eligible beneficiaries increased by 27,365 beneficiaries. We hope this is a positive trend associated with this project that will continue.

The BMS would like to thank all licensed nursing facility staff who have worked diligently to educate and immunize beneficiaries and staff. Statistics reflect that Maine's immunization rates for pneumonia and influenza are higher than the national average.

Congratulations and keep up the good work!

Prior Authorization Moves to Pharmacy Unit

Durable Medical Equipment Prior Authorization has moved from the Professional Claims Review Unit to the Pharmacy Unit. If you have questions regarding DME Prior Authorization, continue to call 287-3081 or 1-800-321-5557 option 5. The fax number is 207-287-8601. The mailing address is: DME Prior Authorization, Pharmacy Unit, SHS 11, Augusta, ME 04333.

Policy governing Durable Medical Equipment and Supplies is found in the Maine Medical Assistance Manual, Chapter II, Section 60 or at the web site: *http://www.state.me.us/sos/cec/rcn/apa/10/ch101.htm*.

Beginning with the next policy revision, all physician providers will receive a copy of the DME policy. Two nurses, Mary-Anne Grover, R.N. and Carole Walsh, R.N., review these requests for medical necessity and meeting Medicaid criteria. Requests are reviewed as soon as possible after receiving a properly *completed* form, including any necessary attachments. Item specific forms are in development. This should help to streamline the process and better enable the prescriber to determine if the patient meets normal criteria for the particular product. As always, your feedback is welcome and needed as we strive to improve this process.

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Blood Lead Screening Rates

Medicaid Lead Testing rates among FP/GPs and Pediatricians, 4/01/2000 - 3/31/2000.

Rank	Family Practice/GP	Age One	% with 1+ Test
1	Roy Nakamura	11	72.7%
2	Deborah A. Learson	21	66.7%
3	Paul J. Davis	19	63.2%
4	Timothy Theobald	13	61.5%
5	Spiros P. Lazas	10	60.0%
5	Heidi Larson	10	60.0%
7	Micheal Lambake	22	59.1%
8	Eugene P. Paluso	24	58.3%
9	Paul W. Templeton	14	57.1%
10	Noah Nesin	16	56.3%

Rank	Family Practice/GP	Age Two	% with 1+ Test
1	Rosalind R. Waldron	11	45.5%
2	Noah Nesin	16	43.8%
3	Timothy Theobald	12	41.7%
4	Kamlesh N. Bajpai	13	38.5%
5	A. Dorney	17	35.3%
6	Donald G. Brushett	46	28.3%
7	H.H. Atkins II	16	25.0%
8	Eugene P. Paluso	17	23.5%
9	Armand Auger	13	23.1%
10	Nicole Cherbuliez	14	21.4%

Rank	Pediatrics	Age One	% with 1+ Test
1	Ann P. Simmons	42	73.8%
2	Scott J. Clough	56	73.2%
2	Gautam S. S. Popli	56	73.2%
4	Iris Silverstein	56	71.4%
5	Colette M. Sabbagh	55	70.9%
6	Melissa Burch	61	68.9%
7	Deborah L. Patten	30	66.7%
7	Rebecca Ayala	30	66.7%
9	William T. Whitney	26	65.4%
10	Lila H. Monahan	72	65.3%

Rank	Pediatrics	Age Two	% with 1+ Test
1	John Hickey	59	50.8%
2	Norman H. Sedar	20	50.0%
2	Reath K. Bobb	10	50.0%
4	Iris Silverman	46	47.8%
5	Lila H. Monahan	44	47.7%
6	Lori Eckerstorfer	24	45.8%
7	Kathleen Hickey	64	45.3%
8	John F. Milliken Jr.	20	45.0%
9	Albert Adams	29	44.8%
10	T. Lever	23	43.5%
10	Kathryn S. Rutledge	23	43.5%

Things You Should Know About of Lead Poisoning

Did you know that lead can be found in places that we are exposed to every day? Many times primary care providers only ask parents of toddlers if they have lead paint in their house or if their home was built prior to 1970. If the parent or caregiver states they have no lead paint or live in a new house, lead testing is not done by the provider. The Center for Disease Control estimates that 1 out of every 6 toddlers has an elevated level of blood lead. There is no data to indicate the number of toddlers that have lead levels below 10mg/dl but go undetected due to lack of blood lead testing.

The Maine Medicaid Program requires lead testing for all children at ages 12 and 24 months. Here are a few examples of potential sources of lead in the home:

- In everyday drinking water. Lead is found in drinking water that is transported through lead pipes or copper pipes with lead solder. This means many older homes with older plumbing may have these features. Brass faucets may also contain lead.
- Dishes, glasses, crystal, bowls and pitchers may contain lead. Leaded glass is a source of lead that can be absorbed into the blood stream. Pottery also may contain lead. Some metal silverware contains lead.
- There is a high probability that houses built prior to 1978 have lead paint. Houses where children can be exposed to lead paint include, daycare, churches, schools, and friends' and relatives' homes. In today's society children spend as much time out of the home as they do in their own home. Many parents are unaware of a child's lead exposure outside of the home.
- Toys and furniture may contain lead. Many individuals have family heirloom toys and furniture that have been passed from one generation to another. These heirlooms may contain lead paint. Metal toys especially the metal cast toys like cars and trucks may contain lead. Furniture with multiple layers of paint or metal may contain lead that can be readily absorbed. Baby cribs and high chairs that have been handed down between generations may contain lead.
- Soil contains lead. Lead can be present in soil forever. It does not wash away or deteriorate over time. If a house containing lead paint was scraped and repainted then the lead from the lead scrapings may be in the soil surrounding a home. Homes located near railways and metal yards have a higher prevalence of lead in soil. Children playing in this soil and putting their hands (or their toys) in their mouth have now been exposed. Homes located near busy roadways are also at higher risk for lead in the soil. Lead from car exhaust settles into soil and will not wash away.
- Window treatments such as mini blinds and other types of blinds may contain either lead in the metal or lead paint.
- Clothing may contain lead dust or particles especially if a family member works in auto repair (radiator repairs), brass/copper manufacturing, pottery or earthenware shops, ship building, or metal manufacturing plants.
- Insecticides may contain lead. This may include those insecticides that are sprayed on the skin to keep away mosquitoes and other biting bugs.
- Families renovating older homes are exposed to lead dust. Lead may be in the old paint and wood. This source of lead can take the form of dust and can easily be inhaled.

The Maine Medicaid EPSDT program will generate a mailing to all caregivers of enrolled children 0-6 years of age who show no evidence of having had a lead test to encourage a visit to their doctor. We hope to raise awareness of the potential of lead poisoning and the danger it presents to our children.

Bright Futures Forms... What Happens to Them?

Bright Futures Forms (BF19s) are sent to the Bureau of Medical Services and take top priority among staff members. Any incomplete forms are returned to the examining provider (examiner).

Why are forms returned?

Forms are returned for two basic reasons: either they are incompletely filled out or they are illegible. The information we ask for is essential to the program. If it's not there or we can't read it, we have to go back to the source... you, the examining provider.

Bureau of Medical Services Quality Improvement Initiative

Once the Bright Futures forms reach the Bureau of Medical Services (BMS), they are first reviewed by our nurses for needed follow-up. All forms are data entered into our database. All forms showing a need for follow-up are sent to EPSDT staff to assist Medicaid and Cub Care members with appropriate coordination for needed care.

Some issues we have seen with form completion:

- Be aware that the data entry staff cannot interpret either the form or the examiner's comments, acronyms or abbreviations. *Comments are welcome*, but please check off the appropriate box per each line as well. We want the examiner to record whether or not s/he considers the exam findings normal for this individual.
- Please enter comments in the comments section on the bottom of the form. It would be helpful if you write the pertinent line item number at the beginning of the comment.
- We have to be able to identify the examiner, so please be certain that we can do that. Having to track down examiner information delays data entry. Signatures are usually not legible, so we ask the examiner to print his/her name and servicing provider number in the header box called "Physician: ID#:" Typically the examiner's servicing provider number is his/her social security number, but this is not always the case. Provider File can confirm servicing provider numbers. *Many examining providers are using stamps that have their printed name and servicing provider number.* This is a time saver and ensures accurate identification of the examiner.
- For accuracy of data entry and follow-up with members, please write legibly. Unfortunately, we do not have the advantage of knowing examining providers well enough to be able to read hand writing in every case. Otherwise, for the patient, it can mean loss of valuable health information, and may mean we overlook a situation that needs follow-up.

REMINDER: Only complete well child visits can be billed using the children's "Preventive Medicine Services" procedure codes. Other types of visits should be billed with the "Office or Other Outpatient Services" procedure codes as appropriate.

GOOD NEWS: We are preparing to revise the Bright Futures (BF19) forms. If you have any suggestions to make them more user friendly or more useful in your practice, please forward them to the Bureau, attention EPSDT Coordinator.

Also, we are offering an electronic version of the BF19 through the "ImmPact" system. If you are enrolled in the ImmPact Immunization Registry, then you have the capability of submitting these forms electronically. If you wish to enroll to enable submitting these forms electronically, please contact Karen Casey at 1-800-867-4775, or e-mail her at: karen.a.hoague-casey@state.me.us

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Thank you for your continued support of the EPSDT Program. We appreciate your participation.

MAINE PRIMECARE

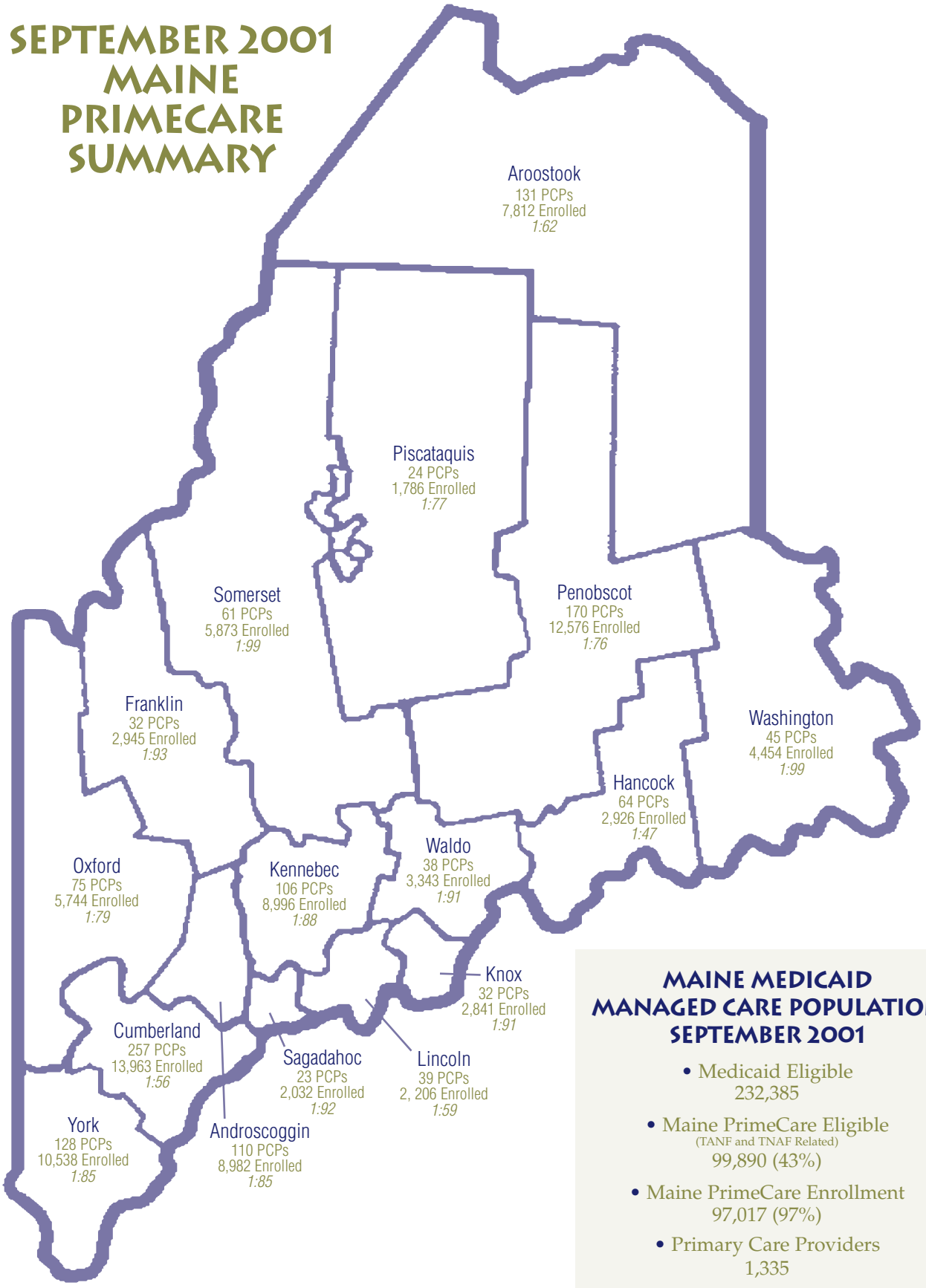
The Maine PrimeCare program began in 1994. Maine PrimeCare is a Primary Care Case Management (PCCM) Statewide program that includes the enrollment of Medicaid beneficiaries who are eligible under TANF, TANF-Related and Cub Care. Primary Care Providers (PCP) enrolled in the program include: MD's, DO's, PA's & NP's. Patients are offered a full range of primary care services including PCP or covering program availability, 24 hours a day, 7-days per week. The population charts below reflect the growth of the Maine PrimeCare program throughout the State as of September 2001.

Medicaid/Cub Care and Maine PrimeCare Managed Care Enrollments as of September 2001

Note: The number of Medicaid eligibles now includes *Healthy Maine Prescriptions* Program eligibles.

County	*Medicaid Eligible*	*Managed Care Eligible*	*% of Medicaid Population*	*Maine PrimeCare Enrolled*	*% of Eligible Population*
Androscoggin	21,990	9,370	43%	8,982	96%
Aroostook	19,936	8,066	40%	7,812	97%
Cumberland	33,876	14,293	42%	13,963	98%
Franklin	6,827	2,977	44%	2,945	99%
Hancock	7,658	3,016	39%	2,926	97%
Kennebec	22,285	9,277	42%	8,996	97%
Knox	6,516	2,925	45%	2,841	97%
Lincoln	5,180	2,295	44%	2,206	96%
Oxford	12,898	5,901	46%	5,744	97%
Penobscot	29,134	12,913	44%	12,576	97%
Piscataquis	4,295	1,843	43%	1,786	97%
Sagadahoc	4,669	2,106	45%	2,032	96%
Somerset	13,445	6,047	45%	5,873	97%
Waldo	7,801	3,462	44%	3,343	97%
Washington	10,408	4,517	43%	4,454	99%
York	25,467	10,882	43%	10,538	97%
Totals	**232,385**	**99,890**	**43%**	**97,017**	**97%**

SEPTEMBER 2001 MAINE PRIMECARE SUMMARY



MAINE MEDICAID MANAGED CARE POPULATION SEPTEMBER 2001

- Medicaid Eligible
  232,385
- Maine PrimeCare Eligible
  (TANF and TNAF Related)
  99,890 (43%)
- Maine PrimeCare Enrollment
  97,017 (97%)
- Primary Care Providers
  1,335
- Primary Care Provider Ration
  1:78

Out-of-State Services

Out-Of-State Services must be requested prior to provision. To request prior authorization:

1. Each eligible member must be currently under the care of a licensed physician practicing in the State of Maine, or within fifteen (15) miles of the Maine/New Hampshire border, or within five (5) miles of the Maine/Canadian border.
2. The request for authorization prior to provision or prior authorization must be made by the Maine physician and other providers expecting to receive reimbursement for services provided out-of-state.
3. The request must be made at least thirty (30) calendar days prior to the date medical care/services are to be provided in another state. The only exception would be for medical or behavioral health emergency cases. In cases of such an emergency, the prior authorization decision will be made as soon as necessary to relieve the emergency. Emergency cases will be given special consideration and should be so identified by the physician requesting approval. Telephone requests, which must be followed by written materials, will be accepted only in emergency situations.
4. Physician's letter must include:
   a. Patient's name;
   b. Patient's Medicaid identification number;
   c. Diagnosis (describe diagnostic studies and treatment completed to date along with results, and clinical records upon which the request for out-of-state referral has been made). Send clinical records to support diagnosis and referral;
   d. Names of physicians and/or facilities to whom the patient has previously been referred in Maine for diagnosis and/or treatment. Send second opinion documentation;
   e. Physicians consulted by attending physician relative to availability of diagnosis and/or recommended treatment in Maine. Send second opinion supporting out-of-state referral;
   f. Recommended treatment or further diagnostic work;
   g. Reasons why medical care cannot be provided in Maine or the next closest location outside the State; and
   h. Names of physicians and facility outside Maine to provide services and date of appointment if known.

For services not covered, see Maine Medical Assistance Manual, ch. II, section 90.07- Physician Services.

Chronic Pain Management Update

In the fall of 2000, the Quality Improvement Division began receiving quarterly reports on beneficiary narcotic utilization patterns. Through tracking and trending of these reports it was noted that over 1,000 beneficiaries in any given quarter were obtaining narcotic prescriptions from 3 or more different prescribers. These prescriptions may be filled at multiple pharmacies and may include narcotic prescriptions obtained from multiple emergency room visits.

The goals set by the QI Division include:

- To ensure Maine Medicaid beneficiaries who have been identified as at risk for over-utilization of medications receive services to assist them in modifying their behaviors
- To ensure Maine Medicaid beneficiaries who have been identified at risk for over-utilization of narcotic medications receive services, which will improve their health status and not place them at higher risk of illness due to improper use of medications. These services are known as Chronic Pain Management.

To date, the voluntary program has received many referrals from providers regarding beneficiary narcotic use, and has identified, through the use of the PDDI report, 2101 beneficiaries with 3 or more prescribers. Letters were sent to beneficiaries informing them of the voluntary pain medicine benefit. The QI Division has enrolled approximately 200 beneficiaries into the new voluntary benefit.

The Quality Improvement Division also submits referral to the SURs unit for beneficiaries that have been identified as potential drug abusers. The SURs restriction program is an involuntary program and is used when the beneficiary has been found to be abusing pain medication, transportation services and/ or emergency room services. As of November 2001, the QI Division has referred 94 beneficiaries for full restriction in areas of pain medicine. These two interventions have produced significant cost savings in the Maine Medicaid Program.

The Quality Improvement Division is developing a report, which will be sent to providers on a quarterly basis regarding beneficiaries narcotic utilization patterns. This report will inform the primary prescriber whether changes in the beneficiaries narcotic use have occurred. We will continue to study data on the effectiveness of these interventions through the up coming year and let providers know any behavioral or fiscal impacts.

Emergency Room Project Update

In the late fall of 1999, the Quality Improvement Division began monitoring beneficiary emergency room utilization patterns. Through this review it was determined that a high number of claims are for beneficiaries with diagnosis of Otitis Media (ear ache), Pharyngitis (sore throat), Common Cold and Cough. Review of this data determined that the beneficiary could obtain better continuity of care if a primary care provider familiar with the medical history of the beneficiary was seen.

The Quality Improvement Division began interventions to affect this change. The goals of the project include:

- To ensure Medicaid beneficiaries receive the best possible services available through their PCPs.
- To provide educational services to those beneficiaries who utilize the Emergency room greater than 2 times in a quarter and over 2 or more quarters.

In spring of 2001, it was noted that there were some beneficiaries who continued to use the emergency room for these diagnoses despite the educational mailing. The Division determined that these repeat users would receive a follow up phone call. The phone call is designed to provide education to the beneficiary, assist them in obtaining a primary care provider, and to determine if there are provider issues that cause this behavior. Baseline data from 7/01/99 to 6/30/00 reflected that 17,868 beneficiaries used the emergency room for one of the 4 diagnoses. From 7/01/00 to 6/30/01, the number of beneficiaries using the emergency room for this diagnoses increased to 18,732. The Quality Improvement Division believed this increase is due to the large increase in Medicaid eligibles due to the changes in eligibility requirements. Data collection to determine the outcome of this education is ongoing.

The Quality Improvement Division also contacts beneficiaries who have been referred by providers regarding emergency room use. Providers may submit a referral form to the Health Benefits Advisor requesting assistance in educating or supporting beneficiaries. The Quality Improvement staff nurses contact beneficiaries and provide education and support once the referral is received. In fiscal year 2001 the QI Division nursing staff had contact with 849 Medicaid beneficiaries regarding issues with the appropriate use of the emergency room.

The QI Division will continue to work to improve beneficiary behavior in this area.

Case Mix/Classification Review Unit

The Case Mix/Classification Review Unit is responsible for the ongoing monitoring of the combined Medicaid/Medicare Reimbursement and Quality Assurance System throughout the state of Maine. The Centers for Medicare and Medicaid Services (CMS formerly the Health Care Financing Administration) mandates the use of a standardized, universal assessment tool Minimum Data Set 2.0 (MDS) for all long-term care Nursing Facility residents. The MDS is the basis for Case Mix payment, Quality Indicators and Resident Assessment Protocols in Nursing Facilities.

The Case Mix Unit is also responsible for the ongoing development, implementation and education of a case mix system for Level II Cost Reimbursed Assisted Living Facilities. Case Mix payment was implemented in July 2001.

Registered Nurses visit all Nursing Facilities and Level II Assisted Living Facilities to review the accuracy of the assessment data.

In Fiscal Year 2001: 391 Nursing Facilities were visited and 4295 records were reviewed. The average error rate (inaccurate MDS) was 10.75%. (Last year it was 10.85%.)

259 Residential Care Facilities were visited and 2218 records were reviewed. The average error rate (inaccurate MDS-RCA) was 18.72%.

Thrity-three Minimum Data Set 2.0 training sessions were held and attendance totaled 313.

Thirty-four MDS-RCA training sessions were held and attendance totaled 336.

MAINE PRIMECARE

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